



## APPLICATION FOR APPROVAL OF RADIOLOGY PROGRAM

State Form 53193 (R1/3-07)

- INSTRUCTIONS:**
1. Fill out all fields. If an item does not apply put "NA" in that field. Do not use abbreviations on this application.
  2. Type or clearly print all information.
  3. Send the completed form to: Indiana State Department of Health, 2 North Meridian Street, 5F, Indianapolis, Indiana 46204.
  4. If you have any questions call (317) 233-7565 or email [radiology@isdh.in.gov](mailto:radiology@isdh.in.gov).

FOR OFFICE USE ONLY			
Date Received		Date of Approval	
<b>DO NOT WRITE ABOVE THIS LINE</b>			
<b>Radiology Program</b>			
Name of Program			
Address (number and street)			
City	State	ZIP Code	
Telephone Number ( )	FAX Number ( )	E-mail Address	
<b>Select Category of Program(s)</b>			
<input type="checkbox"/> Radiologic Technology	<input type="checkbox"/> Radiation Therapy	<input type="checkbox"/> Nuclear Medicine	<input type="checkbox"/> Dental
<input type="checkbox"/> Chest	<input type="checkbox"/> Cardiac Catheterization	<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Podiatric
<b>Program Coordinator</b>			
Name and Title of Program Coordinator			
Address (number and street)			
City	State	ZIP Code	
Telephone Number ( )	FAX Number ( )	E-mail Address	
<b>Additional Information Required</b>			
<ol style="list-style-type: none"><li>1. If your program is approved by the ARRT (American Registry of Radiologic Technologists) or an accrediting organization accepted by them, NMTCB (Nuclear Medicine Technology Certification Board), or the ADA (American Dental Association) you need only submit proof of that approval.</li><li>2. If your program is not approved by the ARRT, NMTCB, or the ADA you must submit a copy of the following information:<ol style="list-style-type: none"><li>a. Detailed curriculum of your program.</li><li>b. Overview of your program.</li><li>c. Location of your program.</li><li>d. Curriculum vitae and/or resume of all faculty showing credentials and educational and professional background.</li><li>e. Description of clinical education and clinical evaluation system.</li><li>f. Description of competency based evaluation system.</li></ol></li></ol>			
<b>Application Affirmation</b>			
I hereby swear or affirm, under the penalties of perjury, that the statements made in this application, and all additional information submitted with it, are true, complete, and correct to the best of my knowledge.			
Signature _____ Date (month, day, year) _____ (Authorized Program Representative)			